

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15996

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1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY in 1b <u>40 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>MASON</u> Last <u>ALLSTON</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>11</u> - Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 5, 1921</u>	9. AGE (In years lost birthday) yrs. <u>46</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARTHUR ALLSTON</u>				14. MOTHER'S MAIDEN NAME <u>MAHALA MASON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Harry Allston, Denton</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>Acute left ventricular dilation due to phy-</u> <u>4200</u> IMMEDIATE CAUSE (a) <u>ical strain</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>? history of Angine Pectoris</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		EXAMINER'S NAME (Type) <u>Harold B. Plummer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>11/11/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City or Town) (County) (State) <u>Denton Car. Md</u>	
24. FUNERAL DIRECTOR <u>Charles Moore Denton</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>NOV 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15997

CERTIFICATE OF DEATH

15989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY In 1b <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Goldsboro</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amanda Jane Anderson</u>		d. STREET ADDRESS <u>Route #1 Box 215 B</u>	
4. DATE OF DEATH Month Day Year <u>11 10 19 67</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 14, 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Kent County, Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Anderson</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Jane Davis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>221-24-4107-A</u>		17. INFORMANT <u>Daughter</u> Address <u>Route #1, Box 215 B, Goldsboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, unknown origin</u> 0534 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>malnutrition, arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> , 19 <u>67</u> , to <u>11-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-9</u> , 19 <u>67</u> , and that death occurred at <u>8:15</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11-11-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u>		22d. ADDRESS <u>Easton, Md. 21601</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centerville D.A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>James H. Butts, Jr., Butts Bur., Centerville, Md.</u>		25a. REC'D. BY REGISTRAR <u>NOV 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

03309

CLINICAL RECORD

7891

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VR A15 (4)
25M 1/67

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15998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G394 11/15/67 ph

15990

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		d. STREET ADDRESS <u>CHAPEL ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Everett Sheldon Blades</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MGR OIL DISTRIBUTOR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN A. BLADES</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZA SHELDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SHELDON S. BLADES Jr</u>		Address <u>EASTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calcific aortic stenosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Pathology</u> , 19 <u>67</u> , to <u>10:00</u> M, that (I) (we) last saw the deceased alive on <u>10:00</u> M, and that death occurred at <u>10:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>9 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton TALBOT MD</u>
24. FUNERAL DIRECTOR <u>Blair Clark</u>		25a. REC'D BY REGISTRAR <u>Easton Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Blair Clark</u>		DATE <u>NOV 13 1967</u>	

15598

STATE OF ALABAMA

1980

ORDER OF THE JUDICIAL COUNCIL OF THE STATE OF ALABAMA

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15999

CERTIFICATE OF DEATH

15991

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN 1b <u>44 hrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>111 North 3rd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Edward</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 1, 1892</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ridgely, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Artemus Brown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown by family</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-5411</u>		17. INFORMANT Address <u>Family 111 North 3rd St, Denton, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>67</u> , to <u>11-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-10</u> 19 <u>67</u> and that death occurred at <u>8:25 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u>				22d. ADDRESS <u>Easton, Md. 21601</u>			
23a. BURIAL, CREMATION, <u>Burial</u> (Specify)		23b. DATE THEREOF <u>Nov. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandtown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hillsboro, (Caroline) MD.</u>	
24. FUNERAL DIRECTOR <u>C. W. Hill-Denton</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15992

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tubercular Hospital</u>		d. STREET ADDRESS <u>200 Glenwood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last <u>Cobb</u>		4. DATE OF DEATH <u>11</u> Month <u>28</u> Day Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/54</u>
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roosevelt Cobb</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mae Caldwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Easton, Md.</u>		Mrs. Anna Cobb, 200 Glenwood Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound (R) lower neck</u> 9190 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>4</u> p.m. <u>28 Nov</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Easton Talbot Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		22. DATE SIGNED <u>30 Nov 67</u>	
EXAMINER'S NAME (Type) <u>THORSTON HARRISON</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Easton-Talbot-Md.</u>
24. FUNERAL DIRECTOR <u>Barbara L. Dashiell</u> Address <u>Easton, Md. 21601</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

Journal of the American Academy of Child and Adolescent Psychiatry 45:10 (October 2006), pp 1251-1259

326

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16001

CERTIFICATE OF DEATH

15993

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
c. LENGTH OF STAY IN 1b <u>3 da.</u>		d. STREET ADDRESS <u>203 S HANSAUX ST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA BARBARA Comegys</u>		4. DATE OF DEATH Month Day Year <u>11 - 17 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1895</u> <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD</u>
13. FATHER'S NAME <u>HENRY GERSTMAYER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH REPP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>HOSPITAL RECORDS EASTON, MD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narrow intra cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic essential hypertension x</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>(?)</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1 July</u> , 19 <u>60</u> , to <u>17 Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 Nov</u> <u>1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thorston Harrison</u>		22b. DATE SIGNED <u>18 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>		22d. ADDRESS <u>Clinton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 20</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN MEMORIAL</u>	23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>
24. FUNERAL DIRECTOR <u>Chas. Judge</u>		25a. REC'D BY REGISTRAR <u>Chas. Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Chas. Judge</u>
		DATE <u>NOV 22 1967</u>	

10000

CERTIFICATE OF DEATH

10000



[Faint, illegible text, likely a certificate of death form with fields for name, age, sex, cause of death, etc.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16002

15984

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>114 S. Commerce St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred SEWARD Dewing</u>		4. DATE OF DEATH Month Day Year <u>Nov. 7 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1878</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Centreville O.A.Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. SEWARD</u>		14. MOTHER'S MAIDEN NAME <u>Lottie A. Milby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-6616-B</u>	
17. INFORMANT <u>Husband</u>		18. ADDRESS <u>114 S. Commerce St. Centreville Md. 21607</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, rt. lower lobe</u> <u>575X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peri-rectal abscess</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ and that death occurred at <u>4:35 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>7 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Centreville, O.A.Co. Md.</u>	
24. FUNERAL DIRECTOR <u>James H. Butler Jr.</u>		25a. REC'D BY REGISTRAR <u>Butler</u>	
25b. REGISTRAR'S SIGNATURE <u>James H. Butler Jr.</u>		25c. DATE <u>NOV 13 1967</u>	

30002

10002

STATE OF TEXAS

County of _____

Know all men by these presents, _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of the County of _____ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

to have and to hold unto the said _____ heirs, assigns and assigns forever.

Given under my hand and seal of office this _____ day of _____ 19____.

Notary Public in and for the State of Texas.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15995

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIDGELY RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Fisher</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-1898</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN WESLEY FISHER</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE SIMPSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>214036102A</u>		17. INFORMANT <u>Maggie Fisher, Bidgely MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiac Compensation</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>loss of lower right leg</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Harold B. Plummer</u>		EXAMINER'S NAME (Type) <u>Harold B. Plummer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>11/8/67</u> Address (Street, city, town, or county) <u>Preston Caroline</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify). <u>BURIAL</u>		23b. DATE THEREOF <u>11-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DEKTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DEKTON-CAROLINE MD</u>	
24. FUNERAL DIRECTOR <u>B.L. Dashiell-Easton, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard S. Judge</u>	

6003

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death of a person, if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

4/18/68

D.O.A. 10 ³⁵ /PM				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15996			
16004				MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Car.</u> ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely, Md.</u> 05-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Rt #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>O'Connor</u> Last <u>Hamilton</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1967</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1903</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Adam Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Bartie Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-12-1377</u>				17. INFORMANT <u>Blanche Hamilton Ridgely, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8164</u> DUE TO <u>Fractures of Skull Left & Right Sides on Rt</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Fracture of Left Femur Proximal end</u> 30mm med (c) <u>Fracture of Right Femur at Head</u>				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism Specimen Taken.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Route 404 7 miles west of R Denton, C. 11 miles with on hwy for</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>11:2</u> 19 <u>67</u>				20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route</u>			
20f. (City or town) (County) (State) <u>Denton Caroline Md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>11/14/67</u>			
ACTUAL SIGNATURE <u>Harold B. Plummer</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Harold B. Plummer</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-6-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>			
23d. LOCATION (City or Town) (County) (State) <u>Goldsboro, Maryland</u>											
24. FUNERAL DIRECTOR <u>J.E. Boulaie</u>				ADDRESS <u>Greensboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 7 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

Chicago

June 21, 1932

June 21, 1932

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16005

15997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY in lb <u>22 days</u>		d. STREET ADDRESS <u>32 South Washington St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PRESTON</u> First <u>SAMUEL</u> Middle <u>HOPE</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>June 29, 1911</u>
9. AGE (In years lost birthday) yrs. <u>56</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Retail Furniture Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Somerset Co., Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Coly S. Hope</u>		14. MOTHER'S MAIDEN NAME <u>Minnie F. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-09-7279</u>	
17. INFORMANT <u>Stanley E. Hope, Cambridge, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>the lung</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on <u>11-22</u> 19 <u>67</u> , and that death occurred at <u>5:45</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trevor</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trevor</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Hurlock, Maryland</u>
24. FUNERAL DIRECTOR <u>Frampton Funeral Home Frederick Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1000

IDENTIFICATION OF DATA

1000

Name

White

June 22, 1971

Owner of Retail Furniture Store

Boonville Co., Maryland

Coly S. House

Minister F. Johnson

No.

122-02-1078

Stanley R. House, Cambridge, Maryland

Robert S. Trevor

Barber, Maryland

Serial

Nov. 28, 1967

West Virginia, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16006

CERTIFICATE OF DEATH

15998

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON, MD</u>		20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S. AURORA ST</u>		d. STREET ADDRESS <u>S. AURORA ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>MAY</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1883</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		12. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MARYLAND</u>	
13. FATHER'S NAME <u>WILLIAM HELSBY</u>		14. MOTHER'S MAIDEN NAME <u>MELVINA ROBINSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>710 WYE AVE EASTON, MARYLAND</u>	
17. INFORMANT <u>REINH. H. JONES</u>		Address <u>710 WYE AVE EASTON, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Spring, 1965</u> to <u>Nov 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>22 Nov 1967</u> , and that death occurred at <u>5:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. Paul White</u>		22b. DATE SIGNED <u>11-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>St. Michaels, MD</u>		22d. ADDRESS <u>St. Michaels, MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Nov 27, 1967</u>		23b. DATE THEREOF <u>SPRINGHILL</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EASTON, MD</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13328

CERTIFICATE OF DEATH

18002

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

16007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15999

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON DOA @ 8:30 am			c. LENGTH OF STAY IN 1b DOA @ 8:30 am		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS MADISON, MD.		
3. NAME OF DECEASED (Type or print) NORCY MARIE KANE			4. DATE OF DEATH 11 3 19 67		
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1922	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN L. KANE		14. MOTHER'S MAIDEN NAME CLARIS KANE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-10-6342		17. INFORMANT CLARIS KANE Address RFD #2 CAMBRIDGE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) marked cardiomegaly					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Louis D. Welty EXAMINER'S NAME (Type) Welty		22. DATE SIGNED 11-3-67		22. DATE SIGNED 11-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/67		23c. NAME OF CEMETERY OR CREMATORY MALONES	
24. FUNERAL DIRECTOR Frederick C. Glais		ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR NOV 6 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY in 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman, Md.		d. STREET ADDRESS 2001	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adam Middle Wadsworth Last Kapisak		4. DATE OF DEATH Month 11 Day 27 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/92
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Talbot Maryland	
11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Kapisak		14. MOTHER'S MAIDEN NAME Anna Novak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-5856	
17. INFORMANT Mrs. Adam Kapisak, Tilghman, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO (c) Coronary Atherosclerosis.		INTERVAL BETWEEN ONSET AND DEATH INSTANT. 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 15 1967 to 1967 , that (I) (we) last saw the deceased alive on Oct. 15 1967 , and that death occurred at 952 P M, from causes and on the date stated above.			
22a. SIGNATURE S. Krect Jr.		22b. DATE SIGNED 11.28.67	
22c. PHYSICIAN'S NAME (Type) S. Krect Jr.		22d. ADDRESS Easton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/67	
23c. NAME OF CEMETERY OR CREMATORY Methodist		23d. LOCATION (City or Town) (County) (State) Tilghman, Md.	
24. FUNERAL DIRECTOR Maurice E. Newberry & Son		25a. REC'D BY REGISTRAR DATE NOV 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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UNITED STATES OF AMERICA

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UNITED STATES DEPARTMENT OF HEALTH
INVESTIGATION OF THE NATIONAL BUREAU OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16009

16001

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BEATRICE</u> Middle <u>P.</u> Last <u>KIRK</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6 - 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR STORE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM L. WEBER</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA J. NEYHART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Willis Kirk - Laurel, Del.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung int,</u> <u>163X</u> DUE TO <u>recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>5:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur B. Cecil, Jr.</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur B. Cecil, Jr., M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 18</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LITTLE BRITAIN</u>	23d. LOCATION (City or Town) (County) (State) <u>LITTLE BRITAIN PA.</u>
24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) - DENTON d. STREET ADDRESS RED #2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE S. Middle MATLOCK Last 4. DATE OF DEATH 11 22 19 67		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3-4-00 9. AGE (In years last birthday) 67 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM SMITH 14. MOTHER'S MAIDEN NAME SARAH HALE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 212-26-4713 17. INFORMANT O. J. MATLOCK, RED #2, DENTON, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia due to nephrosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, Congestive heart failure.		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-22 , 19 67 , to 11-23 , 19 67 , and that death occurred at 4:25 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Robert W. Trever M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11/23/67			
22c. PHYSICIAN'S NAME (Type) Robert W. Trever M.D. 22d. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 25, 1967 23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery 23d. LOCATION (City or Town) (County) (State) Denton, Maryland			
24. FUNERAL DIRECTOR Samson E. Leonard ADDRESS St. Michael Ind 25a. REC'D BY REGISTRAR NOV 28 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

18002

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

4/18/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16011

16003

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY in 1b <u>5th. 15 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SMITHSON</u> RURAL		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Calvin</u> Last <u>McCarty</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9, 1906</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER McCARTY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HARMON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. WALTER McCARTY, TRESTON MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>< 24 Hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>11-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS <u>Easton, Maryland</u>	
22e. M.D.		22f. M.D.	
22g. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22i. BURIAL, CREMATION, REMOVAL (Specify)		22j. DATE THEREOF <u>NOV. 18, 1967</u>	
22k. NAME OF CEMETERY OR CREMATORY <u>CONCORD</u>		22l. LOCATION (City or Town) (County) (State) <u>CONCORD CAROLINE MD.</u>	
22m. FUNERAL DIRECTOR <u>CHARLES MOORE DOWNTON</u>		22n. ADDRESS	
22o. REC'D BY REGISTRAR <u>NOV 20 1967</u>		22p. REGISTRAR'S SIGNATURE <u>Charles Moore</u>	

1881

1881

STATE OF NEW YORK

IN SENATE,
January 1, 1881.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1879.
ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1881.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #9 Film #G-95 12/5/67
CERTIFICATE OF DEATH

16012

16004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>H</u> Last <u>McNeill</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>SAYBROOK, CONN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL McNEILL</u>				14. MOTHER'S MAIDEN NAME <u>TOPSY BUCKEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>578-72807</u>		17. INFORMANT <u>RICHARD McNEILL</u>		Address <u>DENTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) <u>Terminal pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>3 months</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>67</u> , to <u>11-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>67</u> , and that death occurred at <u>10:25</u> P.M., from causes on and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>				22b. DATE SIGNED <u>11-28-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>	
22d. ADDRESS				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>DEC. 2, 1967</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEMORIAL</u>		23d. LOCATION (City or Town) (County) (State) <u>SAYLSBURY Wic. MD</u>	
24. FUNERAL DIRECTOR <u>R. Ellis Clark</u>				25a. REC'D BY REGISTRAR <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2-11-12

OFFICE OF PLANT INDUSTRY

1-12

[Faint, mostly illegible handwritten notes and text, possibly bleed-through from the reverse side of the page.]

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BUREAU OF PLANT INDUSTRY
JAN 12 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16013
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Film #G395 12/4/67 ph
16005
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		d. STREET ADDRESS <u>05.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>McIlvaine</u> Last <u>Keese</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 18, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>4</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES McILVAINE</u>		14. MOTHER'S MAIDEN NAME <u>ROSA PRICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS JAS DIKE, DENTON</u>		Address <u>DENTON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5400</u> DUE TO <u>Acute intestinal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Easton when</u> DUE TO (c) <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-11</u> , 19 <u>67</u> , to <u>11-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-24</u> , 19 <u>67</u> , and that death occurred at <u>10:40</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>11-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BARRETT'S CHAPEL</u>		23d. LOCATION (City or Town) (County) (State) <u>FREDERICK DE L.</u>	
24. FUNERAL DIRECTOR <u>J. VERGIL MOORE</u>		25a. REC'D BY REGISTRAR <u>NOV 30 1967</u>	
ADDRESS <u>DENTON</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1905

1905

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Jury

Signature of Witnesses

Signature of Burial Officer

Signature of Undertaker

Signature of Minister

Signature of Family

Signature of Friends

Signature of Neighbors

Signature of Community

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16014

16006

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
o. COUNTY <i>Talbot</i>		MARYLAND		o. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton (rural)</i>		c. LENGTH OF STAY in 1b <i>13 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton (rural)</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wye Cottage Farm</i>				d. STREET ADDRESS <i>Wye Cottage Farm</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Newbold Robinson</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>28</i> Year <i>1967</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 6, 1903</i>	
				9. AGE (In years and birthday) yrs. <i>64</i>		IF UNDER 1 YEAR Months Days Hours	
				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>M.D.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
				11. BIRTHPLACE (County & State, or foreign country) <i>Washington Co. R.I.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Rowland Rodman Robinson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Peace Hazard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) <i>Yes WW 11</i>		16. SOCIAL SECURITY NO. <i>058-18-2745</i>		17. INFORMANT Address <i>Mrs. John N. Robinson, Easton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the stomach with</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>widespread metastases</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>Uncertain</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1967, to <i>11-28</i> , 1967, that (I) (we) last saw the deceased alive on <i>11-28</i> 1967, and that death occurred at <i>10:30 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Robert W. Trever</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-29-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever M.D.</i>				22d. ADDRESS <i>RD 3 Easton Md. 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>11/30/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>	
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 30 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16015

CERTIFICATE OF DEATH

16007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <i>TALBOT</i>	MARYLAND	a. STATE <i>MD.</i>	b. COUNTY <i>QUEEN ANNE</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GRASSONVILLE, MD.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>MEMORIAL HOSPITAL</i>		d. STREET ADDRESS <i>#1 GRASSONVILLE, MD.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <i>GEORGE W. SCOTT</i>		Month Day Year <i>11 2 1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-5-88</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>QUEEN ANNE</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>GEORGE W. SCOTT</i>	
14. MOTHER'S MAIDEN NAME <i>ANNA ANDERSON</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <i>056-16-1931</i>		17. INFORMANT <i>FAENE GIBSON</i> Address <i>GRASSONVILLE, MD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO (b) <i>Cerebral vascular accident</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>31 Oct</i> , 19 <i>67</i> , to <i>11-2</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-2</i> , 19 <i>67</i> , and that death occurred at <i>8p</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Stephen P. Carney</i>		22b. DATE SIGNED <i>11-3-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>		22d. ADDRESS <i>M.D. Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>NOV 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>GRASSONVILLE, MD</i>	23d. LOCATION (City or Town) (County) (State) <i>GRASSONVILLE QUEEN-IND</i>
24. FUNERAL DIRECTOR <i>B E Dashiell</i>		25a. REC'D BY REGISTRAR <i>NOV 6 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1901

CERTIFICATE OF DEATH

1901

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death", "Date of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16016

16008

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 202 Port Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 202 Port Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Sullivan		4. DATE OF DEATH Month 11 Day 28th Year 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-16
9. AGE (In years lost birthday) yrs. 51		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY None	
13. BIRTHPLACE (State or foreign country) MARYLAND		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME IRVIN SULLIVAN		16. MOTHER'S MAIDEN NAME DELILAH WOOLFORD	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. UNKNOWN	
19. INFORMANT ELEANOR W. ALLEN		Address EASTON, Md. 120 HAMMOND ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post alcoholic convulsions kindle 3222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 29
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3 Hour a.m. 28 Nov 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Street Home	20f. (City or town) (County) (State) Easton Talbot Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Thurston Harrison M.D.		22. DATE SIGNED 4 Dec 67	
EXAMINER'S NAME (Type) THURSTON HARRISON		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-4-67	23c. NAME OF CEMETERY OR CREMATORY RICHARDS MEMORIAL	23d. LOCATION (City or Town) (County) (State) EASTON TALBOT Md.
24. FUNERAL DIRECTOR Barbara L. Dashiell		25a. REC'D BY REGISTRAR DATE DEC 6 1967	
426 Dover Street Easton, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

10008

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

Department of Health

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

D.O.A - 245/pm

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY 83-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington, Va.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL				d. STREET ADDRESS 2791 Washington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sara Middle F. Last Thompson				4. DATE OF DEATH Month 11 Day 26 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1944		9. AGE (In years lost birthday) yrs. 23	IF UNDER 1 YEAR Months 23 Days 26 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles C. Thompson				14. MOTHER'S MAIDEN NAME Frances Meek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 413-70-0472		17. INFORMANT 1531 Peabody Ave., Charles C. Thompson, Memphis, Tenn.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 866X Bilateral Pneumothorax left hemothorax DUE TO (b) Multiple fractures of ribs mainly right side DUE TO (c) Unchecked Parachute fall that didnot open Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Many other fractures see detailed ME report						INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Parachute did not open from 3000 feet					
20c. TIME OF INJURY Month, Day, Year Hour 1:25 a.m. 11/26/67		20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2 miles north		20f. (City or town) (County) (State) Ridgeley Caroline Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Multisple X-rays were used Postmortem							
ACTUAL SIGNATURE Harold B. Plummer		M.D. Harold B. Plummer M.D.		22. DATE SIGNED 11/27/67		22. DATE SIGNED 11/27/67	
EXAMINER'S NAME (Type) Removal		23b. DATE THEREOF 11/29/1967		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or town) (County) (State) Memphis, Tenn.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/1967		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or town) (County) (State) Memphis, Tenn.	
24. FUNERAL DIRECTOR MURCE E. NEUNAM & SON, Easton, Md.				25a. REC'D BY REGISTRAR NOV 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. 4 - Box 3</u>	
3. NAME OF DECEASED (Type or print) <u>Alfred T. Warner Jr</u> First Middle Last		4. DATE OF DEATH <u>11 27 1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1885</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALFRED THOMAS WARNER</u>	
14. MOTHER'S MAIDEN NAME <u>SARA J. FOX</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-01-9183</u>		17. INFORMANT <u>MRS. ALFRED T. WARNER, JR.</u> Address <u>Rt. 4 Box 3 EASTON - MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Chemia.</u> DUE TO (b) <u>Arteriolosclerotic Nephrosclerosis.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>67</u> to <u>11/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>S. Krecht Jr.</u> M.D.		22b. DATE SIGNED <u>11-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. KRECHT, JR.</u>		22d. ADDRESS <u>EASTON, Md.</u>	
23a. BURIAL/CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>NOVEMBER 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD.</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u> ADDRESS <u>EASTON, MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 30 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

10010

10010

CERTIFICATE OF DEATH

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said County, at the City of New York, this 10th day of January, 1901.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16018

16011

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN lb 62 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES - EASTON		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Celestia First Middle Last Weatherby		4. DATE OF DEATH Month Day Year 11 14 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/16/1895	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days 11 14	
IF UNDER 24 HRS. Hours Min. 19 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Hill		14. MOTHER'S MAIDEN NAME Etta Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-24-0323	
17. INFORMANT Roy W. Rouse		Address Lima, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, primary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) site not determined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1992		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-10-1967 to 11-14-1967 , that (I) (we) last saw the deceased alive on 11-10-1967 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Trever M.D.		22b. DATE SIGNED NOV 17 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-17-67	
23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town or county) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Balazs Boulais		25a. REC'D BY REGISTRAR NOV 17 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

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Practical Nurse

John F. Hill

Nursing

State Nurse

Tennis.

U.S.A.

Greensboro

11-12-57

Barclay

Greensboro, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 2 taken from birth certificate									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN <u>39</u> hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u> <u>17.2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>Dudly Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Frances Whaley</u>					4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 26, 1967</u>		9. AGE (In years lost birthday) <u>1</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RALPH CARVEL WHALEY</u>					14. MOTHER'S MAIDEN NAME <u>JANICE J. COOPER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>RALPH CARVEL WHALEY QUEENSTOWN, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic edema, pulmonary</u> <u>7715</u> DUE TO (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>November 28, 1967</u> , and that death occurred at <u>6:35 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>E.C.H. Schmidt</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>28 NOV 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>					22d. ADDRESS <u>Easton, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>NOVEMBER 30-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or town) (County) (State) <u>EASTON TALBOT MD.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>R. Ellis Clark</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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EXHIBIT 22-1011

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THURSDAY 10/10/10

RAIL CARRIED OFF

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

10/10/10

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Ann, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL EASTON</u>		d. STREET ADDRESS <u>17-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>F.</u> Last <u>Whitby</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-93</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u> Hours <u>17</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK WHITBY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SAUNDERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>EDW. WHITBY RIDGELY, MD</u>	
17. INFORMANT <u>EDW. WHITBY</u>		Address <u>RIDGELY, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Uremic syndrome due to arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____		INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> <u>Congestive heart failure due to arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>65</u> to _____, 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> 19 <u>67</u> , and that death occurred at <u>10p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>GREEN MOUNT</u>		23b. DATE THEREOF <u>NOV. 26, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City or Town) (County) (State) <u>HILLSBORO, CAR., MD.</u>	
24. FUNERAL DIRECTOR <u>N. VIRGIL MOORE DENTON</u>		25a. REC'D BY REGISTRAR <u>NOV 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1913

CERTIFICATE OF DEATH

1913

[Faint, illegible text on a death certificate form, likely bleed-through from the reverse side. The form includes fields for name, age, sex, date of death, and cause of death.]

[Faint, illegible text on the right margin, possibly a date stamp or administrative note.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16022

CERTIFICATE OF DEATH

16014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN <u>1 1/2 hr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia, Pennsylvania 19104</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1216 N. 42nd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SABRA T Williams</u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6/27/1916</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Turner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Carroll</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-5765</u>		17. INFORMANT Address <u>Joseph A. Williams, 1216 N. 42nd St. Philadelphia, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Emboli</u> <u>460X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Varicose Vein, both leg</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>12:30</u> P.M. from causes on and on the date stated above.							
22a. SIGNATURE <u>William E. Latimer M.D.</u>				22b. DATE SIGNED <u>22 NOV '67</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. E. Latimer, M.D.</u>				22d. ADDRESS <u>Easton, Md. (Memorial Hospital)</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Talbot Maryland</u>	
24. FUNERAL DIRECTOR <u>B.E. Dashiell</u> ADDRESS <u>426 Dover St. Easton, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1953

CERTIFICATE OF DEATH

1953

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL CENTER FOR VITAL STATISTICS
1600 L STREET, N.W. WASHINGTON, D.C. 20004

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of physician: [illegible]
7. Signature of registrar: [illegible]
8. Date of registration: [illegible]

10. Name of informant: [illegible]
11. Address of informant: [illegible]
12. Signature of informant: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16023

16015

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown Rural c. LENGTH OF STAY IN 1b Rural d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown Rural d. STREET ADDRESS 7-0-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jenesse Wilson		4. DATE OF DEATH Month Day Year II- 16 19 67	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1913 9. AGE (In years last birthday) yrs. 53 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Caroline Md. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Dobson		14. MOTHER'S MAIDEN NAME Ella Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-6216	17. INFORMANT Catherine Downs Address Easton, Md.
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, left vent. failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1-2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema of the lungs, Exogenous obesity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 53 to Nov 1967 , that (I) (we) last saw the deceased alive on 1967 , and that death occurred at 84 M , from causes and on the date stated above.			
22a. SIGNATURE Kurt Lederer		22b. DATE SIGNED 11-20-67	
22c. PHYSICIAN'S NAME (Type) KURT LEDERER		22d. ADDRESS QUEEN ANNE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF II-21- 1967	23c. NAME OF CEMETERY OR CREMATORY Chapel	23d. LOCATION (City or Town) (County) (State) Chapel Talbot Md.
24. FUNERAL DIRECTOR B.L. Dashiell ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE NOV 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1972

OFFICIALS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>AIRPORT MOTEL</u>	
3. NAME OF DECEASED (Type or print) <u>HESTER Marguerite</u> First Middle Last <u>WOLF</u>		4. DATE OF DEATH <u>Nov. 6</u> 19 <u>67</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 5 - 1900</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOTEL MANAGER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>B.A. Co. MARYLAND</u>	
13. FATHER'S NAME <u>MARION TANNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DANSE WOLF - EASTON MD.</u> Address		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstructive Vascular</u> DUE TO <u>Carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/30/67</u> , 19 <u>67</u> to <u>11/6</u> , 19 <u>67</u> , that (I) (the) last saw the deceased alive on <u>11/5</u> , 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert M. McDonald</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert M. McDonald, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 8</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>	23d. LOCATION (City or Town) (County) (State) <u>STEVENSVILLE MD.</u>
24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill and</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u> DATE <u>NOV 10 1967</u>	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10018

RECEIVED BY MAIL

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16025

16017

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY in lb <u>today</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> <u>05-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D. # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>B.</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 31, 1899</u>	
				9. AGE (In years lost birthday) <u>68</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired railroad man & farmer (Penna. R.R.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Caroline County</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Grayson Wright</u>				14. MOTHER'S MAIDEN NAME <u>Laura Towers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-6172</u>		17. INFORMANT <u>Mrs. Audrey Lee Hubbard, Hurlock, Md. R.D. #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271</u> <u>Chronic pulmonary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic obstructive pulmonary emphysema</u> DUE TO (c) <u>> 5 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mths</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-17</u> , 19 <u>67</u> , to <u>11-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>67</u> , and that death occurred at <u>7:12 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>				M.D. <u>Easton, Maryland</u> 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Preston, Maryland</u>	
24. FUNERAL DIRECTOR <u>Frankston Funeral Home Federalsburg Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

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18017

CERTIFICATE OF DEATH

Caroline

Weymouth

February

18017

Stillborn

60

August 31, 1801

White

Male

Resided at Weymouth and at Weymouth, Weymouth County, N.H.

William Clayton Wright

Weymouth

7-6-17 Mrs. Andrew Lee Hubbard, Weymouth, N.H.

No

Weymouth, N.H.

Weymouth, N.H.

7-6-17

Weymouth